tion sheet. He had taken "apply the solution to each wart in turn using the same applicator" and "On each occasion the maximum number of loops applied should not be in excess of 50" to mean "apply up to 50 loops to each wart!" Gross over application to a small number of prepucial warts resulted in marked sub prepuical burns. This reaction prompted him to seek help at our department. Screening for other sexually transmitted disease was negative. He was given hygiene advice and cotrimoxazole 960 mg bd for one week and on review normal anatomy had been restored and his warts had resolved.

Effective treatment of viral warts with any modality be it surgical, chemical, or thermal will result in some degree of normal tissue damage. Local self treatment with podophyllotoxin 0·5% has been advocated to alleviate pressure on clinic and medical time. Purified podophyllotoxin 0·5% in recommended doses is felt to have minimal toxicity compared with that of unpurified podophyllin resin. Local reaction (mostly mild or moderate) with inflammation, erosion, burning and pain can occur in up to 64% of patients.[1] Our first patient required hospital admission for an erroneous diagnosis. The second developed problems due to misinterpretation of the product information. The moderate severity of his burns, however, confirms the underlying lack of serious side effects even in relative local overdosage.

All patients prescribed home therapy should have the procedure explained clearly and demonstrated before ending the consultation. Left to the patient, errors of application may occur both in amount and duration of treatment. Podophyllotoxin is as safe and effective a method of treatment of male genital warts as other modalities, but it is not without side effects.

C WHITE
R A SPARKS
Department of Genito-Urinary Medicine, West Wing, Cardiff Royal Infirmary, Cardiff CF2 1SZ, UK

1 Beutner KR, Conant MA, Friedman-Kien AE, *et al.* Patient applied Podofilox treatment of genital warts. *Lancet* 1989;i:831–4.

Accepted for publication 7 January 1991

MATTERS ARISING

Sexual assault of men: a series

We read with interest the recent paper by Hillman *et al.*[1] This prompted us to review our own experience. Eight men, alleging recent sexual assault, presented to our department within the last three years. The victims ranged in age from 10 to 25 years (mean 16 years). Six of eight patients attended within three months of the assault (range two days to 18 months).

Referrals were arranged by general practitioners (GPs) in two cases, Accident and Emergency departments in two cases and a social worker in one case. Four of the eight assaults were reported to the police.

The assailant was known to two of the victims. One case involved multiple assailants. HIV/AIDS anxiety was a prominent symptom in three patients. Oral and/or anal penetration took place during seven of the eight assaults. Sexual orientation was unknown for six victims and in five of these the assault was their first sexual experience. One patient considered himself to be heterosexual. One man had been exclusively heterosexual prior to the assault, but had had a number of both male and female partners thereafter. Voluntary intercourse had occurred in two patients after the rape and before presentation. Alcohol was reported to be a factor in only one assault.

Three patients had a sexually transmitted infection. These were scabies, rectal chlamydia and rectal gonorrhoea. The patient with rectal gonorrhoea was seen 18 months after the incident and had had a number of partners in the intervening period. All patients were investigated according to standard guidelines.[2] Three patients attended only once. For the other five, average follow-up time was three months. HIV and hepatitis B serological testing were negative in five patients at three months from the time of the assault.

One case is particularly worthy of mention as it involves an infection not heretofore reported in the context of male sexual assault. A 15 year old boy was referred to us by his GP complaining of a four week history of anal soreness. He had run away from home 3 months earlier. He had stayed with a man whom he stated was homosexual, who forced him to have anal intercourse four times against his will, the last occasion being ten days prior to presentation. No condoms were used on any occasion. He had no prior sexual experience. There was no history of intercurrent antibiotic therapy. The boy was mildly withdrawn and very anxious about AIDS. On examination, he was found to have perianal erythema, anal dilatation and two small ulcers at the anal margin. He declined proctoscopy. *Chlamydia trachomatis* was isolated from a blind rectal swab. Rectal cultures for *Neisseria gonorrhoeae* and herpes simplex virus were negative. Gonococcal and chlamydial cultures from the urethra and pharynx were negative. Serological testing for syphilis and hepatitis B were negative at presentation and at three months follow-up. An HIV test was performed at three months following informed consent, the result being negative. The chlamydial infection was treated with oral doxycycline 200 mg daily for one week and subsequent cultures were negative. Counselling and support were provided by health advisors within the department.

We agree with Hillman *et al*[1] that cases of male sexual assault are underreported. More data are required, enabling us to counsel our patients about the risk of acquiring STD, including HIV, following sexual assault.

GRAINNE COURTNEY
S ESTREICH
G E FORSTER
The Ambrose King Centre, The Royal London Hospital, Whitechapel, London E1 1BB, UK

1 Hillman RJ, Tomlinson D, McMillan A, French PD, Harris JRW. Sexual assault of men: a series. *Genitourin Med* 1990;**66**:247–50.
2 Schwarz SK, Whittington WL. Sexual assault and sexually transmitted diseases: Detection and management in adults and children. *Rev Inf Dis* 1990;**12:Suppl 6**:S682–90.

Value of performing biopsies in genitourinary clinics

We fully agree with the views expressed by Arumanayagam and